

Medical History Questionnaire

(Please print clearly and use the back of this page if you need more space)

Today's date: _____

Name: _____

Your age: _____

What is the main reason for your visit today?

Do you have any of these eye symptoms?

- Blurred distance vision Glare, halos around lights
 Blurred reading vision Itching or burning eyes
 Constant double vision Eye mattering or tearing
 Flashing lights or floaters Foreign body sensation
 Red Eyes Dry Eye Eye Pain

Do you have any allergies to any medications?

- None known Yes, which ones? (list below)

Medication Name What reaction did you have?

Which *eye medications* do you currently take?

- None Artificial Tears

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Which *other medications* do you currently take?

- None Aspirin on a daily basis?

Medication Name	Amount	How many times/day
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime
_____	_____	1 2 3 4 at bedtime

Have you ever had any of these eye problems?

- Cataract Serious eye injury
 Glaucoma Iritis/Uveitis
 Macular degeneration Lazy eye
 Wore eye patch as a child Retinal detachment

Other: _____

Have you ever had any of these conditions?

- None
 Stroke Dizziness High blood pressure
 Arthritis Allergies Heart disease
 Diabetes AIDS, HIV Lung diseases
 Cancer Anemia Thyroid disease
 Headaches Other: _____

Have members of your family had any eye diseases?

(This would be your father, mother, sister, brother, grandparents)

- Glaucoma Diabetic eye disease or diabetes
 Cataract Crossed eyes Macular degeneration
 Iritis/Uveitis Blindness Retinal detachment
 Poor Vision Other: _____

Please list any eye surgeries you have had:

- None

Type of Eye Surgery	Which Eye	Year
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_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____
_____	Right Left	_____

Please list any *other* surgeries you have had:

- None

Type of Surgery	Year
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_____	_____
_____	_____
_____	_____

What non-surgery illnesses have caused a hospital stay?

If you have glaucoma:

In what year was the diagnosis first made? _____

Month and year of your last visual field test? _____

Name of your previous ophthalmologist? _____

Do you use? Tobacco Alcohol

Would you like to wear contact lenses?

- Yes Not interested at this time.

What was the approximate date of your last eye examination: _____